The Back Pages

viewpoint

Worth doing badly? Sexual health promotion in primary care

'If you think education is expensive then just try the cost of ignorance sometime,' someone said, neatly summing up the position of those of us urging the adoption of more proactive sexual health promotion in primary care. And of course the cost of ignorance when it comes to sexual health is plain to see in STIs and HIV, unintended pregnancies and abortions, infertility caused by undetected chlamydia — and so the grim litany continues. The cost is not just counted in relation to the health economics and funding implications of treatment, but in the toll taken by failed relationships, psychosexual difficulties, blighted lives, depression — even suicides.

Despite all of this, the short-term costs of promoting sexual health, of averting some of these consequences of ignorance are often treated as insupportable, competing as they do with so many other imperatives. These short-term costs include staff time, the attention diverted from other targets, and finance for resources, such as condoms and information materials. The English Government's Sexual Health Strategy looks to primary care as the cornerstone in sexual health service provision, and flags up promoting sexual health as a key activity — but what does this mean in practice, and indeed in practices?

In my years of sexual health promotion work, it has become clear to me that above all what colleagues in primary care teams — as well as in other health care settings — are hungry for are practical, everyday ways in which they can meet the needs of their service users and clients. Understandably they want to make small changes that do not involve huge new investment, but will nonetheless have significant impact. The bad news is that making such changes — maybe introducing new elements of sexual health promotion or shifting long-established ways of thinking — involves an initial effort, as all change inevitably does. The good news is that probably the most crucial changes to make, and those which will have the most sustained and desirable impact for service users, are shifts in our values, attitudes and perceptions, and these come cost-free.

Even better, the Department of Health website now includes a set of strategies for promoting sexual health — including 10 tips for doing this work in primary care and clinical settings.[1] These tips include small but effective changes — like publicising your practice's sexual health services on a poster in the waiting room (anecdotal evidence tells us people are more likely to ask for services if they know these are on offer). Or ensuring that staff — including receptionists — have relevant training so they are comfortable discussing sexual health and can offer a warm, non-judgemental service.

In all this work, we need to be mindful of the needs of groups who are often marginalised or treated by service providers with nervousness, uncertainty or, in extreme cases, hostility. For example gay men, lesbians and bisexuals understandably may be anxious about reactions if they are open about their sexuality — and we must therefore be explicit about the welcome we offer to allay any fears.[2]

But probably the most agonised-over issue in this area of work is the right of young people to receive appropriate education, support and services. We have become accustomed to — if weary of — our concern to serve them well by offering these entitlements being met with cries of protest from the moral right and religious fundamentalists.[3] Their hysterical accusations of corruption, promiscuity and perversion are in fact belied by research which testifies to the fact that early, comprehensive, emotionally sensitive Sex and Relationships Education protects young people from being pressured into sex, from abuse, from unintended pregnancies and STIs. It is ignorance, not information and awareness, which robs children of their childhood. We need to be educating them to become fulfilled and responsible citizens of the future, capable of establishing and maintaining satisfying, respectful and loving relationships. So a key element of the role of primary care teams is therefore to work with partner agencies to promote young people's sexual health, so safeguarding them and ensuring their future wellbeing.[4]

And if it seems daunting to take on this new focus in the work, then it is worth remembering GK Chesterton's immensely comforting mantra which has seen me through many crises of confidence — 'If a thing's worth doing, it's worth doing badly'.[5] Our work may be flawed and imperfect at first, it may take a while to mature and blossom but there are hundreds — if not thousands — of people out there who will be so glad and grateful for our courage and for our efforts on their behalf.

Jo Adams

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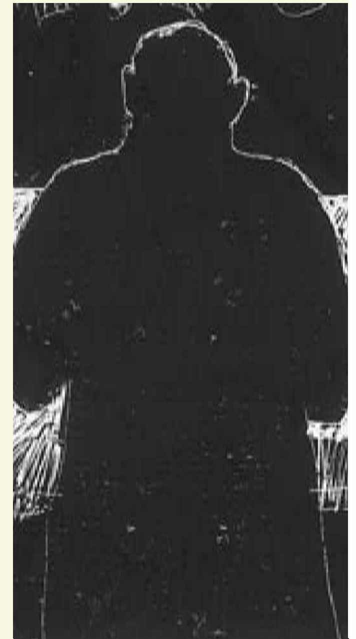

Heart Suture by **Ernst Weiss**

Translated by **Iain Bamforth** on page 996

contents

982 **news**
Aspririn and appraisal
plus Flora Medica
984 **hippocrates**
Appraising 21st century doctors
Mabel Aghadiuno
986 **postcard 6**
Social entrepreneurs — creating better communities
Rowena Young
988 **essay**
Desert Docs
Paul Keeley
990 **digest and reflection**
Wilson at *Parsifal*,
valedictory Neighbour,
on professionalism,
Horder on Hope Simpson,
Hannay on parsnips
Goodman, cross again
995 **Iain Bamforth** on Ernst Weiss
996 **Heart Suture, Ernst Weiss** translated by Iain Bamforth
1000 **Our Contributors**, and From the *Smalleville Gazette*
Saul Miller

news

International Conference on Communication in Healthcare 2004, 14-17 September 2004, Bruges, Belgium

The aim of the conference, organised by the European Association for Communication in Healthcare (EACH) in association with Elsevier and Patient Education & Counseling, is to bring together researchers, teachers, consumers, policy makers and practitioners interested in all aspects of communication in health care, to create networks, to share new work and new ideas, and to provide an enjoyable and motivating experience for all participants. Topics will include:

- Genetic counseling
- Communication using the new technologies
- Didactic materials used for teaching purposes
- The patient and carers experience of health communication
- Undergraduate and postgraduate teaching programmes and their evaluation
- Approaches to shared decision making and empowerment
- The ethics of communication in healthcare
- Approaches in specific topics, with specific subgroups or in difficult situations
- The needs of healthcare professionals
- Communication in healthcare teams
- Communication differences in different healthcare systems
- Quality assessment and improvement
- Media and communication
- Communication in preventive healthcare.

Abstracts are now invited for papers, posters, symposia and workshops on the above topics. Authors should submit abstracts online at http://www.each-conference.com by 1 February 2004.

For further information please visit: www.each-conference.com

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Reflections on annual appraisal

I arrive early, hoping that if I get away on time I will be able to watch my daughter play netball. My appraiser is waiting for me. We shake hands, sit down and immediately I am told to move to a different seat. My appraiser's head is now silhouetted against a bright window, his face in shadow. I feel disadvantaged and dominated before the appraisal has even begun.

During the following 3 hours my professional and personal life is taken apart meticulously and with surgical precision. The pieces fall to the floor and no attempt is made to form them back into a cohesive whole. I feel naked and dirty as I am examined microscopically for any flaws. Every chink in my armour is probed, all weaknesses exposed: I never knew I had so many.

The appraiser has taken notes, but never once does he open the appraisal folder that took me so many hours to collate. Everything is negative. I will stop teaching medical students. I will stop doing research. I will stop fitting coils. The list goes on. I wonder if I should stop practising medicine altogether.

We reach the topic of audit, at which our practice excels, and my heart lifts. We work to high standards, audit across a wide range of subjects and demonstrate improvements year on year. But all of this is dismissed with a wave of the hand as being useless under the new GP contract. I feel as though years of effort have been wasted. An appointments audit is singled out for criticism: I am told that we should have had a gut feeling about the outcome and need not have carried it out.

Turning to his notes, my inquisitor grills me on entries from my learning activity log. He has not recorded dates, so I have to scrabble backwards and forwards through the log frantically trying to find the entries concerned, feeling flustered and foolish. I try to sneak a glance at the clock, but it is behind me. My personal life and health come under scrutiny next. Injuries that required operations on my knees are dismissed as trivial, and inquiries focus on hypothetical future mental health problems. My appraiser is scathing about my choice of GP and wants me to change to another. I resist and the discussion becomes heated. In the end I compromise by agreeing that I may consider changing doctors at a future date. I feel that I have betrayed my doctor, who is a friend.

At last the interrogation ends and the appraisal forms are drawn from their envelope. The appraiser opens my appraisal folder for the first time, just to get my GMC registration number. He jots cursory comments on the forms; the goods and excellents that he writes do not reflect the content of our discussion, but I am too drained to care. The agreed actions are either 'nil new' or 'no problems' or just left blank. Numbed, I sign my agreement.

We turn to the personal development plan next. I ask my appraiser to sign off my existing plan, which has formed a large part of the appraisal folder, and am stunned when he refuses point blank to sign off any part of it, dismissing it all as irrelevant. I realise that many more hours of my work have been wasted. He conjures up a new plan for me in just two short sentences. Meekly, like a schoolchild, I write to his dictation.

I am dismissed briefly to photocopy the appraisal forms, then return to the conference room, where the final charade takes place. The appraisal forms are placed into an envelope, which is then sealed and stamped across its seal, to prove that the documents within will remain confidential, at least until someone at the primary care trust opens the envelope.

It is nearly 3 o'clock and I have missed my daughter's netball match. I have also missed lunch; the appraiser has insisted on seeing all three partners on the same day and I got the midday time slot. I feel a brief moment of pity for him as he downs his sandwiches quickly

Aspirin in the prevention of cancer

Aspirin is used extensively to reduce cardiovascular disease risk. Over the last decade, evidence has been accumulating that it may also reduce the risk of developing certain cancers. The strongest evidence relates to the reduction of colorectal cancer by perhaps 20-30%. There is also suggestive evidence that the drug may reduce the risk of other cancers such as, breast (20-30%), ovarian (20%), oesophageal (50%) and stomach (50%).

On November 10 2003, the Aspirin Foundation convened a 1-day conference on aspirin and cancer to review progress on this exciting area. The review covered the epidemiological evidence from observational studies and randomised trials, and the mechanisms of the aspirin effects. A summary of the speaker's presentations will be available on the Aspirin Foundation website (www.aspirin-foundation.com) in due course.

During the conference, there was much discussion and debate, and repeatedly the question of 'so what do we do?' was raised. Should everyone over 50 or 55, or 60 years old be advised to take aspirin every day? The conference did not seek to provide an answer and I believe that a wide debate should be initiated as a matter of urgency. In some ways, the debate has already been started by the proposal of a polypill that contains aspirin.

There were also repeated calls for further randomised trials to be conducted to test the aspirin and cancer hypothesis. Yet, the calls raise further interesting questions. Who will fund expensive trials on aspirin? Who will do the trials? There are no obvious candidates for the former — that almost makes the latter question somewhat irrelevant.

Other possible research lines were highlighted including health economic analyses and aspirin

before the next appraisal. I am relieved that I have no afternoon surgery today and I doubt whether I could manage one.

Back home, my head throbs. My wife is concerned, as I never have a headache. Tea, paracetamol and abundant sympathy help, but I cannot concentrate and go outside to work on our boat. Concentration lapses here too, and I cut my finger on a knife. Back indoors my wife listens, but I do not want to talk. I am worried about how my partners have coped with their appraisals. I ring them, and find that they have fared much better than I, for which I am grateful. They are solicitous and talk about appealing, but how can one appeal at having passed the appraisal? They talk about complaining, but this could entail having to do the appraisal all over again with someone else, and I could not face that. One partner reports that our dispensary manager was worried that my appraisal would go badly because the appraiser and I have such similar characters. We agree to put my experience down to a personality clash.

That night I lie awake worrying. I watch my clock and see the hours go by until 3 o'clock, then finally get to sleep. Next day, I am late for work, a very rare occurrence; I realise that it is because I do not want to go to work at all. Nevertheless, I scurry in, avoiding colleagues and staff. I try to put on a hearty attitude for the patients, for whom I must try hard to work as normal. Nevertheless, I am indecisive and do not give of my best.

I was told that appraisals were nothing to worry about, and approached this one without concern. I thought that I was well prepared and that I had documented my appraisal folder well. Instead, the experience was a revelation, a humiliating and humbling experience. I have given much and gained little or nothing. This year's appraisal has robbed me of my confidence, but only just for now, and I intend to get it back. There remains a nagging concern: will I have to go through all this again next year?

Michael Archer

mechanisms. On the former, the cost per quality adjusted life year gained by individuals without contraindications who take aspirin from age 50 years was estimated at £100. On the latter, it was suggested that aspirin may be counteracting a dietary deficiency of salicylate and it could be considered as a 'vitamin S supplement'.

'So what do we do?' As the aspirin agenda is now taken forward, two principles of wider aspirin use must be adopted. Firstly, in all situations aspirin must be considered as a complement, and not a competitor to other interventions that promote health. Secondly, aspirin must only be used in situations within which there is good evidence that benefits exceeds risks.

There is no doubt that the conference itself was a great success but I wonder how the far-reaching disease reduction potential of aspirin will be translated into meaningful future action? Watch this space...

Gareth Morgan

flora medica theophrastus bombastus

From the journals, October 2003

***New Eng J Med* Vol 349**

1315 Bare metal stents in the coronary arteries have a significant blockage rate, but this can be reduced nearly to zero by designing them to give out sirolimus. Sirolimus-eluting stents are likely to be standard issue in the future — see also *Lancet* (**362:** 1093).
1324 Epstein-Barr virus RNA is present in a proportion of Hodgkin's lymphomas, and this Danish study shows that these show a consistent time relation to acute glandular fever.
1414 This is the big cohort study of children's asthma we really needed. One in four children from Dunedin, New Zealand, got asthma and kept it into adulthood: the usual suspects, including house dust mite, are found guilty.
1510 Malaria in returning travellers is no great rarity, and sometimes happens despite antimalarial prophylactics taken appropriately, because resting parasites in the liver are beyond their reach. Most are non-*falciparum* strains and usually present more than 2 months after exposure.
1595 A blood marker to tell us in advance which patients with chest pain will have coronary events? Myeloperoxidase sounds promising, but unfortunately it's hard to tell how useful from the data presented.
1614 GPR54 is the gene for puberty. It has a lot to answer for.
1695 Warfarin and INR (International Normalised Ratio) testing will gradually disappear as we start using expensive new antithrombotic drugs with names like Astérix characters. Fondaparinux is better than intravenous heparin for pulmonary embolism.
1703 While ximelagatran is the real star of the show, orally available, and better than warfarin at preventing deep vein thrombosis. An excellent editorial on page 1762 looks at the past, present and future of anticoagulation.

***Lancet* Vol 362**

1123 Will your soul be vibrant in old age? Failing that, you can be fitted with vibrating soles, to help your balance when sensory atrophy takes over.
1133 A good review of the autistic spectrum.
1178 A cohort study of people born in 1945, showing that high birth weight is associated with low systolic blood pressure throughout life. Putting on weight later, however, is the biggest risk factor for hypertension.
1211 As you ponder on achieving your Quality Points for stroke care, here's the review you need.
1347 Laser treatment for acne: zit-zapping proves successful. But only as much as benzoyl peroxide gel.
1389 Watch out for rickets: no Dickensian relic, but a common disease in dark-skinned children in Britain, often associated with deficiency of iron as well as vitamin D.

***JAMA* Vol 290**

1729 Should we still be giving combined hormone replacement to women at high risk of osteoporotic fracture? No, says the Women's Health Initiative study: adverse effects outweigh benefit even in this group.
1859 Another paper this month which helps to sort out children's asthma. Children with hyper-reactive airways are more sensitive to ozone than fine particulate air pollution.
1906 Sleep apnoea is a major risk factor for cardiac and vascular disease, and we still don't know if treating it reduces this. A useful review of the condition.
2015 Exercise for Alzheimer's patients, and behavioural training for their carers, made big differences in this US study. It's time we introduced these into our nursing homes.
2046 Care of the dying doctor: a rare discussion of the topic.
2138 Calm down, or you'll put your blood pressure up. There really is a link, at least in young American males.
2159 Intensive treatment of type 1 diabetes brings lasting reductions in blood pressure and microalbuminaemia.

Other Journals:

Do cats have therapeutic properties? You don't have to be an Ancient Egyptian to think so: a German study in *Allergy* (**58:** 1033) shows that cats in children's bedrooms from the first year of life help to prevent asthma. How good is your clinical decision making? A *Lancet* paper (**362:** 1261) showed that a neural network computer programme outperformed clinicians in managing lower gastrointestinal haemorrhage: a paper in *QJM* (**96:** 763) tests Israeli GPs on chest pain, using a Bayesian approach. They were all over the place, allocating probabilities between 44% and 290%:

'Amazing Bayes, how sweet the sound
To statisticians' ears:
Just when you thought you knew your ground
They have you back in tears.'

Plant of the Month: *Viburnum farreri*

This richly scented plant, originally called *Viburnum fragrans* by its discoverer, Reginald Farrer, was given his name after he died — plant-hunting to the last.

hippocrates

Hippocrates appraises 21st century doctors

MEDICAL science has acquired god-like status, making doctors the lords of life and death. People look to doctors to create their babies, select their embryos, potentially alter their complement of genes, and grant death. Medical science has made tremendous strides in terms of advancement and has opened unimaginable possibilities creating ethical dilemmas for us all. Could the practice of medical ethics today be likened to a game of football where not only the goalposts keep changing, but also the rules, the definition of a player the size of the ground?

Hippocrates is considered to be the 'Father of Medicine'.[1] He introduced a scientific approach to healing that was revolutionary and time-enduring. Wise tenets which form the basis of medicine as we practice it now were inspired directly or indirectly by him. Hippocrates is also renowned for developing the art of ethical bedside care. Medical ethics itself is defined as the 'moral conduct and principles that govern members of the medical profession'.[2] 'Moral' means 'adhering to or directed towards what is right…'[3] while 'principle' is a 'fundamental truth or law as basis of reasoning or action'.[3]

Like many doctors I pronounced the Hippocratic Oath on the day that I graduated. There was for me a certain solemnity and sense of 'honour bound' associated with its taking. After all, hadn't people throughout time shed life's blood to fulfil an oath, or paid the price for broken troth? And yet did I utter antiquated words no longer relevant to medicine today or do we fail to capture their intrinsic wisdom because of their stark and utter simplicity? I wonder... I sometimes wonder what Hippocrates would say to doctors today if he could speed through the centuries on a time machine and alight to inspect Western medicine of the 21st century. What critique might he write on the practice of his ancient Oath in the 21st century? Dare we remove our buffering layer of 21st century-sophistication and allow his scrutiny of our nakedness?

'Nor will I give a woman a pessary to procure abortion. But I will preserve the purity of my life and my art'.[5]

Hippocrates might evince a great deal of confusion as he walks along hospital corridors and finds that along one a trolley is being taken to theatre for a termination of pregnancy, while another corridor leads to a ward where doctors are laboriously striving to save intrauterine life.

'To please no one will I prescribe a deadly drug, nor give advice which may cause his death'.[5]

'Not giving her the right to end her life when she wants is inhuman' 'In a world where individuals like Dr Shipman exist, I would rather not have a euthanasia law thank you',[6] are some of the comments that followed the ruling about the Diane Pretty case. Despite the statement of the World Medical Association last year that voluntary euthanasia is contrary to 'basic ethical principles of medical practice'[7] it is legal in the Netherlands and this has been driven — say the doctors — partly by the will of the people. How many doctors refer patients for terminations and undertake them today not through conviction that it is right but because of its legality. What shall we doctors do if euthanasia becomes legal?

Then if Hippocrates should venture to read April's newspapers he would learn about the Hashmis, the first couple to be given the go ahead by the Human Fertilisation and Embryology Authority to use embryo selection. In the internet instead he would come across a page which describes in DIY fashion 'How to Clone a Human'.[8]

Hippocrates might then ask us to justify our actions, our practice of medicine and above all our decisions and the ethics behind them. Some doctors might use utilitarianism, situation ethics and emotivism to help them make judgments. Hippocrates might argue that in his time there were people who wished abortion or death and perhaps had even more compelling reasons than many today to do so. His oath was therefore born into a society that also had its reasons to reject it. He might question if an ethical principle remains immutable throughout time (despite what may be legal), or if for us the most useful thing about a principle is the supposition that it can always be sacrificed to expediency.

As I sat listening to Thought for the Day on my way into work some time ago, comments of the speaker made uncomfortable listening. She spoke about the recent discovery that children are being bought and sold for human parts. She remarked that everything within us revolts and yet 'while our ancestors did abhor the killing of an unborn child… we think it normal'. She questions if future enlightened generations will look back at our abortion holocaust in horror and that if we 'cultivate embryos for medical convenience, so why not babies? If babies, why not children?'

Of course for those who advocate that human life begins from the moment of conception and speak about the sanctity of life there is never a case for embryo selection, euthanasia and abortion. Medical ethics may seem simpler — but is it?

First do no harm

The question of ethics starts also at the moment in which our pens are poised to write a prescription as Hippocrates'

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hovering shadow in the consulting room reminds us. All too often we have been magnetised by the allure of the pharmaceutical industry and the beautifully presented statistics about the efficacy of its drugs. We have leaned on statistics (defined by Disraeli as lies) like the drunken man leaning on lampposts rather than using them, as Andrew Lang the poet suggests, for enlightenment.[9]

Illich wrote that 'the age of great discoveries in pharmacology lies behind us (referring to a director of the Food and Drug Administration, who said that the drug age already began to decline in 1956).[10] Rich Western countries however, invest in preventive treatments that will benefit only a minority of those who take them for a long time'.[11] In the US 11.5 million adults (5.4% of the adult population) are currently taking atrovastin, simvastatin or pravastatin. Such treatment also has ethical implications as it can lead to perceptions of illness in people who are well.

The percentage of public expenditure on pharmaceuticals as a percentage of gross domestic product in the UK has increased from 0.4% in 1970 to 0.7% in 1996. The cost of prescriptions dispensed increased on average by around 9.3% a year from 1991-1998 while there is the silent cost of 'unredeemed prescriptions' (6-20% of all prescriptions) and unused medication.[12] Paradoxically Cuba, which relies far less on drugs, spends only £7 per capita on health care compared with £750 in the UK and yet it has achieved a life expectancy and infant mortality that is comparable to ours.

Drug costs spiral but so do the number of 'diseases'. An article by Moynihan published in the *BMJ* earlier this year made disturbing reading.[13] It spoke about the corporate sponsored creation of disease and the need for a 'more widespread and rigorous investigation into the role of drug companies in defining and promoting new diseases and disorders'. The WHO similarly asks if the pharmaceutical industry is promoting science or actually sales.[14]

No man is an island. Global health issues, such as the impact of the lack of access to facilities and to pharmaceuticals, are being introduced gradually into the curriculum of medical schools. For many who look at health globally, health professionals have a 'moral imperative' to address global health issues and they should be advocates for the disadvantaged. Yet of 1393 new chemical entities marketed between 1975 and 1999, only 16 were for tropical diseases and tuberculosis.[15] Hippocrates ventures to ask if it is ethical to spend heavily on medicines of limited value? Ethical to base our practice mainly on the statistics and research compiled by non-neutral organisations? Ethical to contribute by wanton prescribing to rising antibiotic resistance which the WHO is describing as a global threat?

And while Hippocrates gets ready to depart on his time machine I see him engrossed in deep thought as he ponders on all that he has seen. His facial expression varies like typical British weather, and as quickly. There is wonder, awe, disbelief, puzzlement, pain… Although lauding much that exists in modern medicine he has, however, found it full of contradictions and inconsistencies. He might discover in Illich a kindred spirit when the latter warns against using technology without restraint in our industrialised society because 'in all other societies recognising sacred limits to the use of sword and plough was a necessary foundation for ethics'.[11] Illich cautions against the just retribution of Nemesis when we doggedly participate in the 'medical pursuits of dreams unchecked by traditional mythology or rational self-restraint', not calculating the price of progress. In our post-modern world where we accept no authority or authority outside of ourselves, where can we find the absolutes of right and wrong? Who can say to us 'You shall not pass!' as Gandalf said to the blearog on the bridge of Barad-dur. (The dwarves in their greed had dug to deep awakening the monster. What monsters will we awaken or create if we fail to check our greedy, covetous pursuit of scientific dreams?)

Oppenheimer lived and died regretting how the atomic bomb was used. He and his contemporaries failed to calculate the cost. Hippocrates taught the art of medical practice almost 2500 years ago. He teaches us today that we cannot afford to blindly make medical ethics suit the times just like someone adjusting a suit that no longer fits or is unfashionable. We have to always scrutinise what we are doing with the honest, courageous eyes of the little boy in the story of the *Emperor's New Clothes* — prepared to see nakedness and folly. If we do not, perhaps history will one day be forced to teach us the lesson drawn from words addressed to the Royal College of Physicians by Theodore Fox in 1965: 'we shall have to learn to refrain from doing things merely because we know how to do them'.[16] Can we?

Mabel Aghadiuno

The Society of Medical Writers

Almost 20 years ago, at an RCGP Examiners' Meeting in Cumbria, two examiners met over a lunchtime pint. They were well established as writers, each with many publications to his credit. They talked at length about writers and the art and craft of writing, and of the enormous reservoir of material in general practice, as well as how medicine has produced so many great writers — poets, playwrights, novelists — Chekhov, Carlos Williams, Bulgakov, Somerset Maugham, Sacks, Cronin, to name a very few. From this came the idea of a group of doctors meeting to discuss writing, share creative experience and criticism, and explore the various genres of literature — and so the General Practitioner Writers' Association was born.

Meetings were held at various weekend venues all over the country, at which doctors 'joined the ranks of those who would go to war over a misplaced comma or semi-colon!' Established writers, and speakers recruited from the membership, talked on various aspects of literature, and each meeting explored a theme — from journalism to travel, from humour to rural life, from creative writing to 'writing under the influence'. The common ground, of course, was medicine — its tragedies, humour, revelation of the human condition, the philosophy underlying care, and the literature it produced. The talks were fairly informal; small groups would hive off to analyse particular aspects of writing, but perhaps best were those long, relaxed discussions late into the night — often by the bar, when the day's topics would be chewed over and literary experiences could be exchanged. Members were encouraged to contribute to the Association's journal, the *GP Writer*, and this disclosed a huge reservoir of talent, producing novels, short stories, poetry — all of a phenomenally high standard, and many members have had their work published.

The Association has recently re-incarnated itself as The Society of Medical Writers, with its journal now, simply, *The Writer*. We wanted to open membership, beyond GP's, to anybody and everybody in medicine and professions related to medicine. Thus, oncologists and dental surgeons, nurses and dermatologists — all are now welcome to join and, in so doing, enhance the vibrancy and intellectual excitement of our mutual exploration of language. *The Writer* is published twice yearly; our next meeting is to be held in May 2004 with the theme — one that challenges us all; 'The medical writer; responsibility, censorship, and the call to publish'.

The study of medical humanities is now, more and more, an integral part of the undergraduate curriculum. Our old Association was really in the vanguard of this movement; our new one continues this trend, attracting increasing interest in what we are and what we do. At a time when measurement — and measurement only — seems to be that which matters most in caring for patients, the Society of Medical Writers offers a forum for discussion of something other and greater than that, i.e., literature and, by extension, the other arts and how they may underpin the whole philosophy of care. But, enough said. Join us.

Michael Lasserson

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Postcards 6 ... Community care
Social entrepreneurs are creating better communities

THE health of communities is crucial to how effective general practice can be in delivering care. Failures in the network of care provided by the community precipitate illness or admission just as often as failures in therapeutics. The old lady who can't get her prescription or whose carer is going on holiday is at risk of these failures just much as those facing the depredations of poverty or substance misuse. Yet most practices struggle to engage with the communities in which they are embedded. Faced with so many more pressing clinical agendas practitioners just grit their teeth and get on and deal with the consequences of failing social networks.

A new breed of social entrepreneur is challenging this understandable fatalism about the state of our communities. Pedal Power is a cycle taxi service created by Dave Kennedy, a man with persistent health problems who wanted to introduce greater mobility into his Salford neighbourhood. Maria Shortis, one of the mothers whose baby died in the Bristol heart unit, is now teaching clinicians how to relate to their patients and improve their diagnosis and care. And the Healthy Communities Collaborative has shown how a community development approach can reduce falls among the elderly by over 50%, and re-admissions from care homes by 80%.

Social entrepreneurs believe passionately in doing something to create better communities. They don't have the usual professional qualifications. The NHS doesn't employ them. But thriving organisations like Pedal Power are testimony to the vision, courage and persistence of their creators.

Social entrepreneurs have, of course, always existed. Just think of the founders of the Red Cross or the Samaritans. Michael Young, the UK's most prolific serial social entrepreneur, created no less than 54 different institutions during a distinguished career, from the Open University and the Consumers' Association, to the National Society for the Education of Sick Children, University of the Third Age and Grandparents Plus.

But what is new is the unprecedented attention social entrepreneurs are receiving. From government ministers hungry for modernisation, to funders and commissioners seeking ways to break the log jam of institutional innovation, people are looking to the energy of entrepreneurs harnessed to social ends to do things differently in communities.

Social entrepreneurship arrived with a bang directly after the 1997 general election when Tony Blair used his first speech to champion their approach. What he and others have recognised is that social entrepreneurs are adept at developing practical 'joined-up' responses to some of our most intractable health and social problems. Untrammelled by the silo thinking, professional training and rewards can encourage. Less constrained by the red tape of statutory administrations, social entrepreneurs were piecing together services in new ways — and often achieving better outcomes.

Some, like Andrew Mawson at the Bromley-by-Bow Healthy Living Centre knew that hospitality and a beautiful physical environment were just as important to great care as clinical excellence. The result is a stunningly beautiful and welcoming centre that helps patients to play an active part in dealing with their problems. Others, such as those running the Kaleidoscope drug project refocused their service away from just meeting immediate needs and towards their clients' wider sense of identity and interests. Along the way they created a range of learning opportunities including a home-grown, web company where drug users could work.

Although we don't think of them like this, general practices already have much of the know-how to work in similar ways — they are, after all, businesses honed to deliver social ends. But, unsurprisingly given other pressures, few exploit their potential to be social entrepreneurs. However, look outside the busy-ness of general practice and a range of policies and opportunities are making it much more likely that your practice will be able to access and build on the energies of social entrepreneurs.

LIFT (Local Improvement Finance Trust) schemes are providing imaginative new spaces and the stipulation that communities must be involved is calling forth a variety of community enterprises. A new legal vehicle, the Community Interest Company, will arrive on the statute books next year, offering a vehicle for the hybrid business trading for a social purpose rather than for pure profit. And charity law is being overhauled for the first time in 100 years, and health has become an explicit and legitimate charitable purpose.

All this signals a wake-up call for general practice. If you can't get funding from your primary care trust for that new service you want to provide, why not re-cast it as a social enterprise and look at non-health funding streams? If you are fed up of trying to get your partnership to work, why not have a contract that really is 'practice-based' and dump the partnership for a Community Interest Company in which all staff — and patients — could be represented?

Some co-ops are already leading the way.

SELDOC, the South East London Doctors' Co-Operative, now offers members a growing range of services including a 24/7 answering service and bulk purchasing for their practices. It has also extended its income stream by selling GP services to local A&E departments and offering police surgeon services.

Social entrepreneurs are entrepreneurial because are they are passionate about achieving a particular change and make it their business to bring it about. Unlike their commercial namesakes they are not completely driven by the bottom line but instead are determined to make a difference for the people they set out to serve. And unlike many people in the public sector social entrepreneurs take personal responsibility for defining their purpose and achieving their goals. That, combined with commercial savvy makes them an indefatigable force for change.

General practice is entering an age of high bioscience. Increasingly the procedures and knowledge of advanced technology will be applied to people in the community rather than in hospital. At the same time those communities themselves are fragmenting and often deteriorating. Delivering effective care (not to mention making the job tolerable) will depend on being able to mobilise all the resources of communities as well as being great at the science. Social entrepreneurs both inside and outside the profession will be key to achieving this.

Rowena Young

Useful websites

Charity Commission:
http://www.charity-commission.gov.uk/

New Economics Foundation:
http://www.neweconomics.org/gen/

Social Enterprise Coalition:
http://www.socialenterprise.org.uk/

School for Social Entrepreneurs:
http://www.sse.org.uk/network/

So you want to be a social entrepreneur?

By the time Michael Young came to impart his experience through the School for Social Entrepreneurs, he had honed the steps to entrepreneurial success to perfection:

1. Talk to lots of people who could effectively champion your idea. Ask those who are genuinely enthusiastic to form a steering group. Michael learned the value of this lesson early. When he began publishing *Which?* magazine, many warned he would face legal actions which would render the project unviable. Michael persuaded Britain's leading libel lawyer to join the board. *Which?* was an unqualified success and today enjoys unbeaten confidence among consumers increasingly sceptical of other brands.

2. Choose a name and constitute. Very few funders or purchasers can pay money to individuals so you will very probably need an institutional form which acts as a conduit for resources. Charitable trusts can largely only make donations to other charities. Becoming a limited company costs £80 and takes only days to achieve. You can apply for funds while an application for charitable status is under consideration. This advice is crude — but this approach suits a large proportion of social ventures. Other options? Host your initiative with an established organisation, or apply for a small grant (average £2000) to UnLtd — the only UK trust supporting individuals (www.unltd.org.uk). Want to know more? Try Companies House or the Charity Commission.

3. Run a pilot or undertake your first commissions on a pro bono basis. Write up or present the results authoritatively. Take your findings or fledgling portfolio to funders or new customers — then ask them to buy in. Lots of people make the mistake of seeking funds before they've demonstrated a track record or the viability of an idea and find themselves in a dispiriting cycle of rejection. The golden rule: never be blocked into inaction.

Getting a purchase on health

Health and economic activity are tightly bound together. On the one hand 'the NHS is the largest single organisation in the UK — it is a huge and powerful buyer of goods and services. As a consumer of energy, a producer of waste, a cause of travel and a commissioner of building works, its potential impact on health and on the environmental, social and economic fabric of our lives is without parallel'.[1] On the other hand, employment and economic activity are themselves powerful predictors of health.

So it makes sense to ask how the massive buying power of the NHS could be used to improve local economies and local lives. If the NHS could be turned, even marginally, towards local purchases or to support burgeoning social enterprises, we would get the double benefit of the directly purchased service and a healthier, more economically active, population.

So what kind of services might the NHS purchase locally? Food is an obvious choice — local produce is fresher and has lower transport costs than imported food. Another could be childcare — crèches could improve recruitment as well as providing local employment. Direct booking will create new call services alongside existing NHS Direct centres — we could insist that at least 25% of people employed in booking centres be disabled.

But to achieve this shift requires canny commissioning. Discriminating in favour of local producers or the disabled means using EU competition rules to write tenders that are most easily met by local providers.[2] Will we be able to do this on top of all the other pressures? Or will stressed and impoverished managers go on contracting out billions to large corporations that offer simplicity and a deceptively cheap bottom line?

Paul Hodgkin

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Desert docs

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THIS year we have seen war fought by British and American forces in the desert. This is particularly poignant as it marks the 60th anniversary of the end of the desert war in North Africa and the defeat of Rommel's forces. This article tells the story of the doctors who served with an elite group of troops operating behind the lines in the North African desert and Southern Europe in challenging and at times dangerous conditions.

The Long Range Desert Group

The Long Range Desert Group (LRDG) was formed as a result of the inspiration of a remarkable man, Ralph Bagnold, FRS. Bagnold had lived in Egypt and in the late 1920s and early 1930s had led a group of like-minded enthusiasts on expeditions into the desert, mapping areas that had not previously been explored by non-Bedouins. Bagnold was so enthused by the desert that he became eminent in its study and published *The Physics of Blown Sand and Desert Dunes* in 1941.[1] Bagnold earns a mention in the novel *The English Patient* and indeed undertook expeditions with the principle character, Laszlo Almasy.[2] In 1939 on his way to a posting in East Africa, Bagnold stopped over in Cairo and put the idea to General Wavell that a force able to penetrate the desert to the south of the only ommunications in a narrow strip along the North African coast would give the Allies an advantage over the German–Italian axis. His idea was greeted with enthusiasm and Bagnold was given freedom to requisition whatever equipment he required.

Ralph Bagnold, FRS
Bagnold Collection, Churchill College, Cambridge

So it was that the Long Range Desert Group (LRDG) was born. It was supplied with 15- and 30cwt Chevrolet trucks equipped with heavy machine guns, and it was in these that patrols of an officer and 10 or so men would undertake journeys through the Sand Sea of over a thousand miles. Provisions were limited by what could be carried.[3]

Initially the LRDG undertook covert surveillance, particularly the 'road watch', which involved hidden observation of enemy supply routes by two men at a time. This gathered vital information about enemy troop movements. There was a cost, however. Lying still behind a small bush or patch of scrub, with little cover, for a 24-hour shift in the heat of daytime and the cold of night time, with only tinned rations, observing every item of traffic on the road, was a test of nerve and stamina.[4] The average patrol lasted 3 weeks, in which the group of 10 or so men relied on self-discipline and mutual dependence. The officer was known simply as 'skipper' while other men referred to each other by first names or nicknames. Rather than traditional military rules of unquestioning obedience and summary punishment, the units developed an 'entirely novel approach to discipline' in which officers had to explain the reasons for a required action.[5]

Desert medicine

The medical cover for the unit was the medical officer (MO), Captain Richard Pike Lawson. Dick Lawson, qualified in 1939, was commissioned at the outbreak of war and was seconded from the Royal Army Medical Corps (RAMC) to LRDG HQ. Captain Lawson was assisted by medical orderlies with each patrol. Some of the orderlies were volunteers from the RAMC, others were interested individuals from other army units. Much of Lawson's work was in bringing these orderlies to a high standard of medical knowledge, being aware of the fact that they would be isolated in the desert with their patrols for weeks at a time, with limited resources and little chance of evacuation to a field hospital.

Treating a patient who might have to move over 100 miles a day over rocky desert in great heat in a Chevrolet 30cwt truck, with a primitive suspension, was hardly ideal. With tinned rations, high desert temperatures and only a gallon a day of water for all uses, constipation proved a problem. At times improvisation was the order of the day and grease guns were occasionally used to administer enemas.

At times a primitive form of telemedicine was employed. On one occasion, a patrol commander, Captain Olivey, signalled to HQ:

The LRDG Chevrolet converted into an ambulance for desert use
Imperial War Museum, London

essay

'ARAB CORPORAL HAS TEMP. 100 PULSE 90 SYMPTOMS APPENDICITIS FROM 1400 ADVISE TREATMENT'.

Lawson returned the following instructions:

'KEEP IN SEMI SITTING POSITION KNEES SLIGHTLY RAISED
SMALL DRINKS OF WATER OR WEAK TEA WITH SUGAR ONLY
WATER BOTTLE FILLED HOT WATER TO RIGHT SIDE
NO REPEAT NO APERIENTS
DOVER [simple analgesia] FOR PAIN MORPHIA IF BAD
IF CONDITION DETERIORATES SEND JAGHBUB [a desert base south of Tobruk] IN TWO TRUCKS'.

The patient recovered in the next couple of days without needing to be moved.[6]

Captain Richard Pike Lawson inside the Chevrolet converted to an ambulance Imperial War Museum, London

Desert sores were also a particular problem — especially as infected sores could not be treated with antibiotics and water for cleaning was scarce. Added to this, flies were prolific:

'My God! How we came to hate those flies. And what a trial they became at the sick parades, clustering round the desert sores, or the exudates that had seeped through the dressings and bandages. Sometimes you would see a man waiting his turn, quite unaware of the black, rosette-shaped cluster of flies that had grouped round his sore, until, noticing their activity, he would slash at them in his fury and start the ulcer bleeding afresh.'[7]

Daring raids

In the second phase of their activity in the African Desert, the LRDG found a new and even more dangerous role. In the summer of 1941, a lieutenant in the Scots Guards called David Stirling formed a unit with a more lethal intent than the LRDG. This unit eventually became the Special Air Service (SAS) Regiment. His notion was to cause as much damage by going behind enemy lines and destroying aircraft, fuel, ordinance — in short, anything useful to the enemy. This work was naturally appealing to the LRDG who had been operating behind enemy lines for over a year. Initially, the LRDG helped these operations out by delivering the SAS to within walking distance of their intended targets and picking them up when they had done their damage. For this service they became known by the SAS as the 'Libyan Desert Taxi Service'. Later, when raiding became more successful, the LRDG took on some of this work themselves. So, it was that the LRDG undertook to raid Italian positions at Barce.

On the night of the 13 September 1942 it was planned that a combination of Commandos, SAS and LRDG would simultaneously attack enemy airfields and defences in the Cyrenaica area of northern Libya at Bengazi, Tobruk and Barce. The LRDG undertook the Barce raid on its own. They left Lawson with a truck as a rendezvous some miles outside Barce. Moving into the area with little opposition after cutting telephone lines, two patrols destroyed 24 aeroplanes and damaged 12 others before setting light to a vast quantity of enemy fuel at the airfield. The second patrol destroyed lines of communication in the town before finishing off their enterprises with a grenade attack on the local barracks. They reassembled in the early hours of the next morning after some skirmishes on the way out of Barce. Their activities had not gone unnoticed, however, and after reassembling as daylight came they were ambushed by 200 local troops. They then came under fire for most of the rest of the day from enemy aircraft. Six men in the party received serious wounds, which Lawson treated under heavy fire. Ten trucks were destroyed and the wounded party limped on in one truck and a damaged jeep. Over the next 3 days they covered 250 miles through the desert to a landing ground from where they were evacuated first to an oasis base at Kufra where they were stabilised, and thence to hospital in Cairo.[8]

For his action in the field Lawson was awarded the Military Cross. In his citation for the award, particular attention was paid to the fact that he shielded his wounded patients with his own body under fire from hostile aircraft when exposed in the desert without cover.[9] Lawson was later captured by Germans in the brave but unsuccessful attempt by the LRDG to recapture the island of Levita in the Dodecanese in late 1943, and spent the remainder of the war as a prisoner.

After the desert

With the desert war concluded in 1943, senior commanders in the British Army realised that they could successfully use the skills acquired by the LRDG in other theatres. New volunteers were recruited and these, together with the original men of the LRDG, trained in mountain warfare and parachuting in the Lebanon. One of their instructors was Dr Griffith Pugh, ostensibly also their MO, who would later climb Everest with Sir John Hunt. With Dick Lawson's capture the LRDG acquired a new MO, Captain Michael Parsons of the RAMC who had qualified in 1942.

While Parsons did not have to face the challenges of the desert, he took on new tasks meeting the needs of now disparate patrols in the Balkans. At one stage he had to drop by parachute into Albania in order to treat the LRDG commander who had fallen down a ravine and sustained a fractured vertebra. Captain Parsons had carried with him a bottle of whiskey, strapped to his leg, with which to celebrate his patient's birthday.

Thus behind the lines, Parsons became something of a 'barefoot doctor', teaching paramedical skills to the partisans with which the LRDG was working, and operating at night on the wounded by the light of an oil lamp. Eventually, he and a party of four others trekked by pony across Albania, visiting and tending to different patrols. The final leg of their journey was a 3-day march by foot to the coast where they were picked up by the Royal Navy and conveyed back to Italy.

After the war

The LRDG was disbanded on the 1 August 1945. One might speculate that had it had a different name, the LRDG might have survived and been deployed in other conflicts. The covert reconnaissance work undertaken by the LRDG was later taken on by other special forces units, such as the SAS, and continues to this day. It had earned high praise, for as Colonel David Stirling, was to say: 'In my view the LRDG was the finest of all units serving in the desert'.[4]

Richard Lawson was liberated from his POW camp at the end of the war in Europe. He returned to England and took up general practice in Hampshire until his retirement. Michael Parsons undertook surgical training and became a consultant ENT surgeon in Croydon. When speaking of their experiences at reunions in later years, they and their LRDG comrades were diffident about their wartime exploits. Certainly, others performed daring and dangerous medical work behind enemy lines.[10] Their story shows that ordinary people are capable, in difficult circumstances, of performing remarkable deeds.

Paul Keeley

Parsifal
Welsh National Opera
Birmingham Hippodrome, Nov; Liverpool and Bristol, December

IT'S been a good year for the Wagner followers among us. Scottish Opera's Ring Cycle was a rare treat, as was the Royal Opera's Lohengrin in June. Now it's the turn of Welsh National Opera and Parsifal. Wagner's last Opera, which as the programme reminds us, was a mere 37 years in the writing, requires a certain amount of preparation. The performance started at 4.30 in the afternoon and we emerged just 5 minutes under 6 hours later — it certainly seemed like Autumn when we went in and very definitely Winter when we emerged. As someone said to me only last week, becoming involved in Wagner is like watching your life ebb away. Anyway, suitably prepared, with a pre-performance BigMac and can of Red Bull to see me through the First Act, and suitably attired in the requisite Wagnerite black shirt (not polo-neck — you have to draw the line somewhere) in we went.

The production itself has been around a year or two — I remembered bits of it from its first incarnation at the Edinburgh Festival 5 years or so ago. It is fair to say that it didn't seem to be to everyone's liking. The chap in front of me put his spectacles away in the first interval — I thought he had just given up on the surtitles, which, sited above the stage, were guaranteed to give anyone in the front five rows vertebrobasilar blackouts if any attempt was made to read them. However, he assured me it was the stage he didn't want to look at any more, not the words! I suspect it might have been the appearance of Amfortas, laid on what I took to be a discarded trolley from one of Birmingham's 'modernising' A&E units, and bandaged up like an escapee from the set of *The Mummy* he probably took objection to.

When the curtain goes up on Act 2, we see the Flower Maidens each sat in front of a mirror. Indeed Kundry's first appearance in Act 2 is when the lighting changes and the reflection of Klingsor who has been looking at himself, changes to the image of Kundry stood behind the two-way mirror. Now I'm not really one for mixing work with pleasure, but you really can't look at all these mirrors and changing images and not let you mind drift briefly to the new GMS contract, can you? Indeed, the final gesture of Parsifal in Act 1, a shrug of the shoulders indicating complete lack of understanding as to what he had just witnessed stirred similar recollections.

What of the music? One of the main draws of the evening was the conducting of the Russian born music director of Glyndebourne Festival Opera, Vladimir Jurowski, and he didn't disappoint. I am sure many of you Wagner readers will disagree, but I often find the first hour of Parsifal hard going — not in the hands of Jurowski, who captivates the listener from the first note of the prelude for the full 110 minutes to the first interval. The Second Act, which contains the best music to my mind, was positively incandescent with orchestra responding and playing magnificently. The singing was all superb. In particular, the searing intensity of Robert Hayward's Amfortas, despite his swathes of bandaging, was unforgettable and Sara Fulgoni, who looked a bit awkward in the role of Kundry in the earlier scenes, rose to the occasion in Act 2 and got better and better. Also worthy of special mention was Donald Maxwell's Klingsor — it's a pity Wagner didn't give him more to sing!

There are further performances in Liverpool and Bristol in December, albeit with a different conductor, and I recommend anyone thinking of giving Parsifal a try, to book now. The production might be a bit quirky, but the music and singing are first-rate. I may have watched 355 minutes of my life ebb away, but it was worth every minute. In fact it was so good I'm already booked for Liverpool!

Paul Wilson

Parsifal and the flower maidens. © Clive Barda

The Healing Continuum: Medical Humanities and the Good Doctor

17-18 October 2003, New York

OCTOBER 2003 saw the fourth medical humanities conference this year held in New York entitled *The healing continuum: medical humanities and the good doctor.* This was the second conference held in partnership between University College London and New York University School of Medicine.

As a medical student at UCL I have now completed 4 years of my medical training and this year I am one of nine students taking the brand new intercalated BSc in Medical Humanities. For those not yet acquainted with the concept of medical humanities, it is comprised of subjects including history, literature, philosophy, anthropology, film, creative writing and visual arts. In our particular degree we study how these subjects can be viewed in a medical context and can help us to develop our skills as future doctors. The aim of the 2-day conference was to gather together an extremely interesting and diverse range of people, from all over the US, Canada, the UK and beyond, who share an interest in how the humanities can be used to foster good doctors.

The first day was dedicated to defining the qualities that make a good doctor from the perspective of patient, caregiver and physician, and debating how medical humanities can play a role in developing these qualities. On the second day we heard how foundations and publishing can support those people interested in pursuing a path in the humanities. Finally, we ended the conference by discussing an area of particular interest to me, how professionalism can be fostered in medical education and practicing physicians. I had been invited, along with three other students and two junior doctors, to speak on this panel. Although a slightly daunting invitation considering the excellent presentations and workshops held up until this point, I really valued the opportunity to express my opinion on what I had experienced as a student. It is an unfortunate truth that medical students are rarely required to have an opinion during their training, and possibly even more rarely asked to express it. I was therefore delighted to be given the chance to have my own views heard. This conference was extremely well organised, and it hardly needs mentioning that New York was a superb setting for the event. It brought together people from very different walks of life, each coming with their own perspective on medicine and humanities. I found it very exciting to be able to talk with this diverse group of people on an equal level, and have definitely come away with a much greater understanding of the use of these subjects in medicine. I shall return to my BSc and medical courses with a new enthusiasm and shall be taking it upon myself to spread the word. I am left with one question though — will the endeavour make me a better doctor?

Hannah Perry

roger neighbour *behind the lines*

On professionalism

'Start by grabbing the reader's attention' is the gist of Lesson One on most creative writing courses. OK then. Professional is the new gay.

Or rather, 'professional' is the new 'gay'. Note the quotation marks. The word 'professional' is currently experiencing the same dizzy shifts in connotation latterly undergone by the word 'gay'. In the 1960s, the 'brightly coloured' or 'carefree' meanings of 'gay' were supplanted by the 'homosexual' one, so that (as the *New Oxford Dictionary* puts it) 'the word cannot readily be used unselfconsciously in these older senses without arousing a sense of *double entendre*.'

Time was, being a professional was a matter of pride and a badge of integrity. Joining a profession entailed mastering a large corpus of knowledge — knowledge vital to the wellbeing of the ordinary individual, but more complex and extensive than every individual could to hope to acquire. Professional training was long and preferably arduous, undertaken within a tradition of self-imposed discipline, of responsibility willingly accepted and of service willingly given. 'A professional is a man who can do his job when he doesn't feel like it. An amateur is a man who can't do his job even when he does feel like it.'[1] And in exchange for hard work and sacrifice, the professional deserved appreciation and generous reward.

But — for societies as much as for individuals — gratitude is a difficult thing to sustain without its turning to resentment. The medical profession in particular — dealing, sometimes disdainfully, with people's messier misfortunes — was bound sooner or later to attract criticism of the who-do-they-think-they-arevariety. One notorious example was Ivan Illich's 1975 polemic *Medical nemesis*, beginning: 'The medical establishment has become a major threat to health', (by causing more pathology — physical, spiritual and social — through its activities than ever it relieves).[2] Illich is in the tradition of Bernard Shaw's well-known: 'All professions are conspiracies against the laity',[3] (though we might smile wryly at the ambivalence that led Shaw later to write, in his preface to *Misalliance*: 'Optimistic lies have such immense therapeutic value that a doctor who cannot tell them convincingly has mistaken his profession.') And Ogden Nash's needle goes straight to the point of maximum tenderness: 'Professional men, they have no cares; whatever happens, they get theirs.'[4]

Unfortunately the snipers are still out there, some of them in commanding vantage points. Julian Le Grand, professor of Social Policy at LSE and currently on secondment to Number 10 as a policy adviser, has recently published a book whose innocuous title, *Motivation, Agency and public policy*, camouflages a powerful blunderbuss aimed at the professional heart.[5] You can just see its muzzle peeping out from the subtitle — *of knights and knaves, pawns and queens.* His thesis is that the motivation of professionals is more complicated than either pure altruism or pure self-interest, that patients are neither all-passive nor all-powerful, and that healthcare policy should be designed with these realities in mind.

So far, so true: thank you for noticing. But it's all too predictable what would happen when the hacks and sub-editors got hold of it. Beneath a headline proclaiming 'Public workers are "knaves", says Blair aide', *The Independent on Sunday* of 12 October said, 'Doctors … who resist the Government's plans for reform are "knaves" motivated by plain self-interest.' Concerns that reform might pose a threat to the spirit of caring are 'likely to take the form of arrogant, insensitive, uncaring, overweening behaviour, even from professionals.'[6]

Grrrr. Professor Le Grand's powerful warning against the dangers of oversimplification may well itself have been oversimplified. But I'm too cross to enjoy the irony. It's almost irresistible to wonder, pot-and-kettle-like, whether Downing Street policy advisors are uniquely devoid of self-interest. Likewise to ask, sauce-for-goose-and-gander-like, whether — if professionalism means genuine accountability, job-specific training and willingness to subject one's motivation to unflinching scrutiny — we might not be better served by a parliament of professionalised decision-makers.

But this sloganeering, point-scoring and name-calling doesn't help; it really, really does not help. Well, only if it succeeds in clearing the ground for the growth of mutual respect. We could start by trying to reclaim some dignity for the word 'professional', just as 'gay' has reclaimed a new dignity from the opprobrium of the recent past. How? By constant explanation. By constant advocacy. By the constant demonstration of good professionalism in action. And by the constant expectation that professionalism on the part of doctors will be reciprocated by those with whom we cooperate in the pursuit of an NHS to be proud of.

Anyway: it's 2 years since Alec invited me to contribute to these pages. It's been great fun sounding off from 'behind the lines'. But now, as I become your President, it's time to pipe down and run out onto the pitch. Thank you for having me.

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david hannay

On buttering parsnips

It has been suggested that buttered parsnips would be an appropriate signature dish for the RCGP.[1] People are divided in two by many things, such as being vegetarian or not. Those who are not are usually omnivores. I eat anything within reason, with one exception — parsnips — cannot stand them. Is this nurture or nature, possibly the result of a deprived wartime childhood, or perhaps genetic? I suspect the latter, because few are neutral about parsnips — you either love them, or loathe them like Ogden Nash:

The parsnip, children, I repeat
Is simply an anemic beat
Some people call the parsnip edible
Myself, I find this claim incredible.[2]

To continue the medical analogy Allbut wrote of 'The pale or parsnip tint which belongs to nephritis'.[3] The word parsnip comes from the Latin '*pastinere*' meaning to dig, with the second syllable from the same root as the Scottish 'neap' for turnip — an altogether pleasanter taste. The Romans had other rather vulgar allusions to parsnips on which I will not elaborate.

As for buttering parsnips, presumably to make them palatable, the phrase appears in the 17th century 'Faire words butter noe parsnips',[4] and again in the 18th century, 'Business is business and fine words you know butter no parsnips'.[5] Although Trollope disagreed, 'I often tell 'em how wrong folks are to say that soft words butter no parsnips, and hard words break no bones'.[6]

Having voted for the new contract, general practitioners will have to make the best of it. Those who do not get what they like, have to like what they get. To be opposed to the new contract is not to be nostalgic for the status quo, and still less for the old contract which only came into effect in 1990 and had many problems.[7] Rather, there was concern that core values were being lost and could have been continued in ways which emphasized professional responsibility rather than formula-related pay.[8]

In the 1990 contract, the Jarman Index,[9] based on subjective views, was used to calculate deprivation payments, although there was evidence that higher deprivation indices might be linked to less hours worked and fewer patients seen.[10] In the present contract the calculation of quality payments is already being questioned.[11]

If the College has a role in making the new contract more palatable, then we will have to forget about cholesterol and butter away.[1] But that does not mean closing our eyes to what has been happening in pallid resignation, but rather being alert to the possibilities of enhancing the values of general practice even when choking on parsnips.

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an appreciation - robert e

I want to celebrate the life of Robert Edgar Hope-Simpson, who died earlier this year at the age of 95 years.

He spent 43 years in active general practice, 13 of them at Beaminster in Dorset, and 30 years at Cirencester. I recently attended the memorial service at which Sir Denis Pereira Gray gave the Address. The parish church at Cirencester, which is exceptionally large, was full to overflowing. It was obvious that the town had lost a citizen who was both loved and famous, although he had retired from active practice in 1975.

Edgar was famous because of his research, but he never appeared to seek fame (he was a Quaker). His two-partner practice was unique, because in 1947 it became a Medical Research Council Unit. This later took the form of a virologist working continuously with a doctor who had from the start of his career maintained typed case records, with research on the epidemiology of common infectious diseases particularly in mind. A special diary enabled Edgar to see the connections between patients, their diseases and the places where they lived.

His career-long interest in the manner of transmission of the influenza virus was first stirred by the great epidemic of 1932-3, the year in which he entered general practice. It culminated in a book, published in 1992,[1] that questioned the theory of person-to-person transmission being enough to explain the simultaneous appearance of influenza in places far apart. His findings were based not only on observation in his practice, but also on extensive historical research into past epidemics.

His most important contribution concerned the behaviour of the herpes zoster virus in his practice population.

In 1953 there was still uncertainty whether the zoster virus was the same as the varicella virus. Informed of an outbreak of varicella in

Sir Henry Dale, drawn by Edgar Hope-Simpson

Edgar Hope-Simpson

the isolated community of a Shetland island, he seized the opportunity. The outbreak started from a household in which there had been a very recent case of zoster. Travelling there at short notice and interviewing all the families involved, he was able to convince himself that the same virus was responsible for both diseases. A carefully argued article was published later that year in the *Lancet*.[2]

But was zoster transmitted through contact with another zoster patient? Or through contact with varicella? Or through re-activation of a virus latent since an attack of varicella earlier in the same person's life? The two doctors recorded 192 cases over a period of 16 years in Cirencester. Their evidence clearly supported the hypothesis that this condition arises only through reactivation of latent virus and is not 'caught' at all.[3]

The memorial occasion included an exhibition. In it were not only photographs, manuscripts or reprints of some of the 80 research papers that Edgar published, but also drawings done by him — the most memorable being a large pencil drawing of his father-in-law, Sir Henry Dale, pharmacologist.

Edgar was honoured by the Royal Society of Medicine (in the Proceedings of which his most important research had been published); by the Royal College of General Practitioners, of which he was a foundation member; by the Faculty of Public Health Medicine and by Case Western University — among other institutions. He received the award of the OBE from the Queen in 1963.

It is said that he was never heard to speak ill of anyone.

John Horder

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Pile 'em high, teach 'em cheap

We need more doctors. Doctors graduate from medical schools. Ergo, we need more, and bigger, medical schools. While this solution has been evolving, medical schools have been shedding clinicians because their research is not deemed safe to submit to the Research Assessment Exercises, and have been taking on scientists who know a lot about genes. Some years ago, Southmead's Medical Advisory Committee (largely made up of consultants) was addressed by a representative of the Medical Faculty. He spoke in riddles for 20 minutes or so, but his take-home message was, 'We're taking on more students, and you're going to teach them'. Not all that long before, the university, wanting to save money, had withdrawn its yearly stipend to consultants. Withdrawing £80 per annum probably didn't force anyone into penury, but it's the thought that counts.

We now have 50% more medical students. The new Peninsula Medical School means that the far south-west is no longer available for Bristol placements. To complete the picture, the ever-increasing political demand to treat patients as day cases makes it difficult for students to see patients, especially the less complicated ones.

Everyone involved in teaching medical students, including the students, wants to be sure that we find the best way of getting them through the expanding curriculum. The Medical Education Committee has issued a document for discussion. Much of it is definitions and organisation: how to refer to blocks of teaching, who sits on what sub-committee, and to whom they report. Organising the course is difficult: making sure the larger number of students will be taught adequately when spread through a number of hospitals, some of which have until now been involved only informally. Not sitting on any of the committees, I leave others to query the detail. But some of the stated principles worry me.

Whatever new structure is agreed, the document tells us that it 'needs to take account of the lack of congruence between the departmental structure and the curriculum Unit structure, and find ways of ensuring coherence to the overall design and delivery of the MB ChB programme'.

I think I know what is meant, but I shouldn't have to wonder: this has come from a university. Even more obscure is, 'The [new] system implies a significant shift in the conceptualisation of the role and function of clinical academic staff within the University of Bristol. These staff become central to leading and organising the [degree] programme, ensuring its academic rigour and currency.'

I think this means, 'We're taking on more students; you're going to teach them; and we'll tell you how to do it.' Although I could be wrong.

An introduction

Ernst Weiss was born into a Jewish family in Brünn, now Brno, the capital of Moravia, in 1882, and studied medicine at the universities of Prague and Vienna, graduating in 1908. Initially attracted to psychoanalysis, nascent in Vienna, he decided to train as a surgeon. He had the good fortune to be an understudy in Berne to the famous Theodor Kocher, who won the Nobel Prize for Medicine for his work on the thyroid gland when Weiss was his assistant (Kocher left his name on several surgical techniques, clinical signs and the manoeuvre, familiar to casualty officers everywhere, for reducing dislocated shoulders), and in Berlin to the bullish August Bier: both served as the model for the surgeon in *Heart Suture* (1918).

Written after the years of Weiss' friendship with Franz Kafka, and military service on the eastern front with the Austrian army, *Heart Suture* might be said to combine both of Weiss' medical interests: not only is the conduct of the operation described with an unerring (as we would now say 'surgical') precision, but the patient, whose self-inflicted stab wound to the heart is repaired in the nick of time, is 'put under' by her former lover, a medical student doubling as anaesthetist. That the weapon happens to be a pen makes for melodrama: there is manifest irony in the 'General' doing battle to hinder a very 'literary' act of self-destruction. (For the record, the first recorded attempt at suturing the heart was made in Frankfurt in 1896, and pericardial repair was to become a common procedure only in the 1930s: Weiss is writing science fiction.)

Weiss once wrote that he became a writer only because Kocher instructed him to 'write up' his cases. His first novel *The Galley* (1913), which has a radiologist as its protagonist, was followed by a score of other works, several of them featuring doctors in the main role. Only one of his novels, *Boëtius von Orlamünde* (1928), has been translated into English (as *The Aristocrat*). In 1934, in face of the mounting Nazi threat, Weiss, like many writers from the old Austro–Hungarian empire, emigrated to Paris. Years of penury were to follow. On 15 June, 1940, the day the German troops marched into the city, Weiss took his life. He had reason to fear for it. In 1938, he had submitted a hastily-written manuscript, *Der Augenzeuge* (*The Eyewitness*), for a literary competition sponsored by the American Guild for German Cultural Freedom, a trust which arranged American sponsorship for emigrant writers. An unknown writer won the competition, but a copy of Weiss' manuscript survived the war, unlike his manuscripts in Paris, to be republished in 1963.

The material is nothing if not sensational: *The Eyewitness* is an expanded case report of a patient ('A.H.') admitted to a sanatorium in Pasewalk in 1918 with eye problems after being gassed at the front in Flanders. Weiss apparently learned about the incident directly from Hitler's psychiatrist Edmund Forster, whom he met in Paris in 1933: a few weeks later Forster was found dead, and the files documenting Hitler's episode of hysterical blindness vanished. Weiss' fiction follows Forster's account closely. News of the armistice in November 1918 causes A.H. to lose his sight completely: he doesn't want to 'see' Germany in defeat. So the psychiatrist decides to restore sight to this 'incorrigible fantasiser' by bolstering his self-belief under hypnosis; and Corporal A.H. leaves the clinic to begin his self-chosen mission as surgeon to the body politic. The psychiatrist (yet another doctor–hero) confesses that he *has* been blind: he has cured the symptom, but not the sickness at its source. 'I didn't want to see it because a kind of passion had seized me. I too wanted to do, to act. I wanted to rule, and every act is more or less a ruling, a change, an elevation of one's self above fate.' He has been midwife to the great lie.

Iain Bamforth

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Heart suture by Ernst Weiss

Medical student Friedrich von B., tall, blond and young, passionately fond of 'major surgery', but certainly not averse to other kinds of passions, among which a certain Hildegard Anneliese had played a considerable if, in recent times, not entirely happy role, was taken on at the beginning of December as an unpaid assistant in the surgical clinic of privy councillor O., known to his students because of his military appearance and his imposing bearing as the General. This appointment was not unrelated to an old duelling club friendship between the professor and the student's father. Friedrich von B. did all sorts of jobs in the clinic, initially without attracting the notice of his father's friend; they were odd jobs, but essential and responsible tasks: anaesthesics, dressings, minor operations. Sometimes he found himself just mooning about, waiting to be asked to do something, or he portered patients to the lectures that took place on weekdays between a quarter to ten and eleven.

On one of these occasions, on January 17, the Professor gave a lecture on malignant tumours. With pride, he wheeled forward his permanent successes, patients he had operated on three or five years before, even one person he had treated seven and a half years before when he had just taken up his surgical teaching post in the city, and who, like the others, had stayed healthy and not relapsed. The operations had been difficult; and the fact that the patients were in remission for so long was a triumph of surgery, the benefit of early and radical intervention. So the university clinic sent letters to the old patients summoning them back, reassuring them that if they came from the outlying areas their travelling expenses would be met.

Now they were parked on a bench in the wide corridor which led from the wards to the lecture hall. Five men, three women; four from the town, and four from the country. Although the registrar had told them not to talk about their illness (a general prohibition for all patients in the clinic), they had now been talking with each other for an hour about nothing else; a couple of them rucked up their shirts in order to display their operation scars, others merely making a sign over their clothes to show where and how long the incision had been, although they tended to exaggerate just how long. Then they proudly followed the students into the lecture room, smoothing their clothes, and one of the women broke out in a sweat having, in her haste, been unable to put her gloves on quickly enough.

The General revelled in surgical optimism. He compared the fate of the patients in remission with the fate of others with the same illness who had long since been pushing up the daisies, during which he put his giant arms on the shoulders of his frail patient, who was getting on a bit, and rotated the woman like a puppet to the right and left, then promptly turned his back to her so that he could draw a schema of the operation procedure on the blackboard for his students, and while doing so held the chalk in his right hand, and the patient's notes in his left containing in detail all the exact facts of the case, the very same dossier which his registrar had just handed over to him. Then in a formally perfect recital he explained the operating technique, gave a critical evaluation of the pros and cons of each method, estimated the corresponding prognoses with the help of carefully applied statistics and completely forgot, while doing so, that the eight people all this was about were standing in the lecture room, which also happened to be an operating theatre.

He was still completely absorbed in his surgical considerations when his old registrar, Professor E., suddenly burst into the lecture room and flustered something in his ear. The excitement transmitted itself immediately to the surgeon, flushing his face red as if he had drunk a good claret: only the old duelling club scar shone out in its bright cherry red. A deep crease appeared in the General's forehead indicating that he was deep in thought, while the registrar shooed the eight healed patients out of the hall like a gaggle of geese. The professor immediately let the water run in a washing stand set aside for his exclusive use. Then he reversed the hourglass that was standing on a glass shelf. Ten minutes' worth of brown sand started running out: the exact length of time for hand rinsing and surgical antisepsis. The student helped the General with his 'toilet', and while the General alternately spoke and scrubbed his hands he tied a large yellow waterproof gown with a brass chain around his bullish neck which was now as claret-red as his face. Without looking, the General put his feet into black galoshes that went over his ankles.

In a moment he was transformed from the academic lecturer into another kind of human being; his voice, his bearing, his glance were all different. With his stiff brush he scrubbed at his fingers, hands, front and back, and forearms up to the elbows. With a press of his foot he squeezed soap from an automatic dispenser, and soon his arm was covered with white soapsuds. Once again everything would be rinsed, the blotchy skin, redder and redder because of the scrubbing, would re-emerge, only to disappear again in lather.

Standing beside him, his assistant was his spitting image.

Now the General turned to the lecture room:

> 'A stroke of luck, regrettably increasingly rare. A suicide attempt in the vicinity of the clinic. A young woman, mere slip of a girl. Stabbed herself in the heart. Probably requires suturing. Timely operation. Most untimely suicide instrument, an old-fashioned pen with a nasty steel nib. Office girl. Relatively advantageous circumstances, gentlemen, given that the fell object has lodged in the wound and thereby hindered exsanguination. Fortune in her misfortune.
>
> 'By the way, an achievement too, to hit the heart with such a crude weapon. The method, which hopefully all of you now, even the gentlemen in the top row (please don't stand up gentlemen whatever you do, the dust is frightful and terribly dangerous) — now, the method which I hope to demonstrate to you is new and is one of the many, quite sterling contributions to science of the xFirst assistant, as usual, will be yourself, Herr Oberarzt, the second Herr Glikker, and the third Herr Schillerling; anaesthesia will be in the hands of our model student here, one of your own number, gentlemen, who is already quite a little anaesthetist. In cases like this we need anaesthesia by the book, not just any kind but excess pressure anaesthesia; after all we'll be guddling about inside the chest cage.
>
> 'Once medicine could do nothing for injuries to the heart, but that was ages ago; since Rehn we have been able to deal with stab, and even — though, of course, only in the rarest cases — bullet wounds to the heart; we can tackle all these situations, provided, gentlemen, that the patient is brought to us alive on the table! No less than three of every five cases survive provided they can be operated upon in time. There can be no doubt that if the Austrian archduke, heir to the throne, had, after his heart wound in Sarajevo ... Well, let us move on from that painful chapter! Warm the saline apparatus. Sister, prepare the adrenalin, one in a thousand solution, yes, I merely wanted to say, there are methods against every kind of injury, the only thing we can't prevent is murder. You can suture the wound, but you can't cure the heart. Our anaesthetist will monitor the pulse. Don't forget the rib dilator, in fact have all bone instruments ready. Indications for operation in such cases are straightforward: you start the operation

as soon as the patient is in front of you. First aid is decisive. So not a second to lose, where have you put the patient? Wheel her in straightaway! Formalities and extensive paperwork are superfluous; I operate even without the consent of the patient who, in such cases, is often not quite *compus mentis*, and without the consent of the relatives, who don't have a blind shimmer … No matter: let's go get 'em, but only in strictest adherence to the rules of bacterial antisepsis. No excuses here; we must and most certainly will follow the rules of asepsis, for we're on the point of opening one of the most susceptible cavities of the body, and one prone moreover to suppuration, in a word the chest cage and the pericardium. Ah, there she is. Forwards! Be careful! Gently does it!'

Tall, blond, somewhat thoughtless medical student Friedrich von B. saw Hildegard Anneliese again, the person who had played such a considerable, even if not always happy role in his recent past.

The instruments were being boiled in their very own electrically heated sterilisers. Thick clouds of steam rose from the instrument drums and thinned out in the amphitheatrical space. Even though it was almost midday, the lecture room was gloomy. 'Light!' said the General. The lamps, which were positioned immediately under the ceiling like stage lights, hissed on, and an almost pure white shadowless light poured out over the operation table, the professor and his assistant and over the lowest row of the audience. The face of a clock, which had been indistinct until that moment, now showed not quite two minutes past eleven. The General was silent. All that could be heard was the bubbling of the water, the metallic clatter of the instruments shifting here and there in the seething water, and the whispering of the spectators.

Now the girl who had tried to kill herself gave a dull groan. She didn't cry out; she seemed to be holding her breath in, for every movement of her ribcage caused her pain. The students looked down into the depths and saw the girl's face under the glare of the ceiling lights, sickly yellow, the upper lip drawn down over the lower, moist, and around her face a tangle of damp, light-brown hair. She screwed her pale green eyes tight shut, then opened them again wide, the eyelids trembling, and the reflection of the lights kept flitting from one side of her eye to the other. The clothing on the upper part of her body had already been cut with scissors, and a fine gauze dressing spread over her chest; in one place it stuck up jaggedly, and this place moved rhythmically. There was calm. The General and the assistants had stopped scouring their arms and hands with their brushes, and eyed the patient.

It seemed as if it were deepest night. Stillness. Only the seething of the water, the bubbling of the instrument holder, the hissing of the light and the groaning that came every time the patient breathed out. The General had motioned to the head sister. With sterile forceps she removed the gauze dressing very gently from the patient, a woman like herself, as if she were afraid of hurting her. Beneath the left breast of the patient the shaft of the pen was visible; it bobbed up and down with the heart beat, as if it were being pulled down by a hidden power until it was no more than a mere dot, and then it forced itself up again as if drawing a fine line.

'The very first thing to notice,' said the General while scrubbing his now lobster-red arms with renewed intensity, 'is that consciousness is entirely intact. Apart from the understandable degree of shock associated with such cases. And no haemorrhage. External bleeding has ceased. It can only have been minimal anyway.'

He beckoned the student Friedrich von B. to come closer to the victim. His muscular male arms shone in the blazing light like glossy metal.

'Onwards! Let's get started! Anaesthesia!'

The student heaved his shoulders. His entire body trembled in horror and he was able to control himself only by summoning all his strength.

For excess pressure anaesthesia he needed a special apparatus which should have been at hand. But being in need of minor repair it had been taken into another room, and now, where every second counted, it was missing, and nobody dared tell the boss. The nurses were rapidly opening large nickel-plated drums with protective coats, drapes, hoods, rubber gloves and dressing material; in tandem they pulled out white square-shaped sheets, opened them out, spread them under the patient while the head sister lifted the girl's upper body with extreme delicacy. The lower body was then draped, only the upper body and the face that was becoming paler with every second remained free. The hands were strapped down, and a broad strap tightened across the thighs.

In the hourglass nine minutes had elapsed. The great clacking sieves containing the instruments were lifted out of the seething water. Huge clouds of steam rose up. With practised movements the head sister separated the metal instruments out in systematically ordered rows on small, mobile tables; similar types of instrument next to each other, the larger ones on the right, the smaller on the left. Scissors, straight and curved, four-finger crochets, bone extractors, vessel clamps, forceps, needle holders, boxes with sickle-shaped needles and boxes with straight needles, silk and cat-gut thread wound on glass bobbins ordered according to tensile strength.

The hourglass had almost run out, the student looked around the hall, but the anaesthetic apparatus was still not there. The sound of running water stopped abruptly. 'Iodine!' said the surgeon.

Only now, in the last minute, was the anaesthetic device trundled in, a complicated apparatus. The rust-coloured bomb with the red valve was the oxygen cylinder, the blue bomb with the blue valve was liquid air, and the green valve supplied the anaesthetic agent. Flashing manometer, gleaming, with fluid-filled gauges for controlling every breath.

While the professor was being gowned in a white operating costume and someone else was putting a white bonnet on his head, the student held the close-fitting reddish rubber mask over the girl's nose and mouth. Mixed with air, the anaesthetic agent trickled through a transparent glass tube in large beads. 'Breathe deeply! Breathe deeply!' said the student in a flat voice to the girl. Without a word the girl stubbornly shook her head. With feeble movements she pushed the mask away as best she could. The mask slipped back in place, but her pale face turned and tried to evade it. She opened her mouth, she wanted to scream, she wanted to defend herself. She tried to whisper a request and pursed her mouth. But not a word, only the same long-drawn-out dull groaning emerged from completely bloodless lips that had taken on the pallor of her skin.

'Iodine!' repeated the General as he pulled on rubber gloves. Both breasts, the skin up to the throat and down to the navel were now covered with a metallic blue-brown sheet, and a broad piece of dressing material had been applied to the operating field.

In the middle of the brown expanse the steel-nibbed pen moved up and down, but less energetically now, faster and weaker, thrilling, driven by the helpless trembling heart. Her respiratory movements which until now had been visible, became flatter. The eyes were now wide open, they darted desperately, but lucidly, around the large room.
Difficult to believe that a human being with such a wound was still lucid, that she knew what she was doing, what she was suffering.

Already the General's face bore that

peculiar, almost serene, quite disengaged expression indicating that he had thought the operation down to the last detail with all possible complications so that its technical execution was a mere formality — but why was the patient still conscious? Yes, she almost showed more signs of life than before, and her eyes sought and finally found the eyes of her former lover.

Not a second to lose, thought the student, it has to be. But what should he say to her, how could he make her understand everything, bring her to reason, what should he remind her of? Who was guilty? Who would make it good again? Two minutes before death? Twelve past eleven.

'And the pulse?' asked the General.

The young medical student fumbled on the beautiful soft neck of the girl, the contours of which were known to him from what seemed ages ago. With the tips of his index and middle fingers he softly touched the moist, smooth, lukewarm skin.

'Carotid impalpable. I can feel nothing on the carotid.'

But the girl had felt his hand. Did she still love him? Did she still want to live? Did she regret it? Was she still the same girl she had been a couple of minutes before?

The eyelids closed then, the long eyelashes came together and formed a thick, light-brown line that almost looked brazen in the glare of the lights. The lips opened delicately. The milk-white teeth stood out amid the pale coral red of the gums. She breathed out in his face, she drew the ether–air mixture in with shallow, rapid breaths. Thirteen minutes past eleven.

'We must get started now. Is she under? No, not yet? Doesn't matter. Life is the main thing, anaesthesia is secondary. War is war. Up and at 'em. Tilt the head as deep as you can. Avoid cerebral anaemia, preserve the spinal breathing centres and so on above all else. The blood leaking from the wound is pressing on the heart externally and filling the pericardial sac. The brilliant Ernst Bergmann has termed this cardiac tamponade. There we are, a little lower yet, fine, enough.'

The table had noiselessly lowered itself by means of a hydraulic device. The student felt the girl's head, with its matted silken hair, sink in his lap. Was she still alive? Was she suffering? She wasn't groaning any more. Was she sleeping? Was she awake? Was she dead?

'Instruments, please!'

From a dazzlingly bright alcohol-filled dish the Oberarzt lifted a thin curved nickel scalpel with a steely blue gleaming blade; it was as fine as the fin of a fish. The General took it at the upper end, almost in the same way as a painter takes a brush, and with the cutting edge, as if he was trying to outline an arabesque, drew an arcuate line which started in the middle of the upper torso and circled round the bottom edge of the left breast. Pale streaks of red appeared at the margins of the line, but without any obvious blood loss. The assistants hooked their dilators to the margins of the wound on the right and left and pulled it apart. The patient groaned. Then she was silent. The student gave ether. The knife vanished from the surgeon's hand, although nobody saw how, and now a series of instruments appeared in his right hand, large and small, sharp and blunt, ablating and extirpating, invasive and dilating. The surgeon's hands and those of his assistants were sheathed in close-fitting, red-coloured gloves made of the thinnest rubber which clung so intimately to the fingers that the contours of the nails were apparent. All that was apparent in the operating field was the General's long-fingered hand making gestures that seemed casual and fortuitous, but in fact were absolutely precise and methodical. Other hands were busy holding the wound margins open, handing over instruments or little bundles of gauze, and doing all the various ancillary tasks which the General directed mostly with his gaze; his voice was reserved only for the most important commands. What he said was more for the students in the gallery, to make the particular step of his operation clear to them:

'You see, unfortunately hardly any blood to be seen. Blood pressure is minimal. Careful with the anaesthesia. Let her groan if you must, only the bare minimum so that she doesn't come to on us. She's in shock, will hardly be sensitive to pain. Here, in the subcutaneous tissue is a crepitus, air's coming out under pressure from the wounded rib cage. What to do? First we'll remove a section of sternum, and then we'll open the ribs. We're making an access to the heart, a kind of door. There we have to cut through two, three, in fact four ribs while sparing the periosteum because everything has to knit together again. The whole thing is very straightforward. Air again. With every breathing motion the wound sucks in air from the exterior. Heads not too close to the wound! We don't want any infection. Give more pressure with the anaesthesia! Just a trace of ether and lots of oxygen. Now we can have a go at the enemy. Grip the suicide instrument externally with a pair of forceps, hold it firm. And now we're forcing it back the way it came, that is the trajectory the pen took: you can see the track still marked with ink. Now we're going to remove it, turn it externally a little, good! Careful traction now, a bit more force, more, splendid! It's out now. Good, into the collection with it. Silly woman, in her despair she grabs for the nearest thing to hand. And now for the ribs, be careful, rib cutters, yes, oppose them carefully, first the finger underneath and now I'm pressing through and here's the next. Finger under and then lift skin, bone and membrane in a single flap upwards, without exerting force. One, two, and another one, one, two, back, back and let it go, but don't slip, hold the skin flap steady, damn it, easy does it, gently, gently, good!'

Friedrich von B. held his hand over the girl's mouth; the flow of her breathing was hardly perceptible.

'Don't let air in the mask! Continue excess pressure. Don't worry, she's still breathing, the situation is easier to assess at our end, we can see the lung inflating; check your anaesthesia, do the best you can. Watch out! There is the pericardium! Onwards!

Toothed clamp. Clamp.

By Helen Wilson

Larger! Smaller! Medium-sized, be careful and turn the thing a little towards the exterior! Another one, another one, keep going just like that! Here's the wound in the pericardium, jagged, zigzag, it must have gone in that way, not a simple incision obviously, because at the moment it was wounded the pericardium was under tension, torquing, as with every heart beat. Goitre-probe, we want to go in, deeper, deeper!'

The probe, an elongated finger-like instrument made of nickel-plated steel slipped smoothly through the wound into its depths, blood-filled and dark.

'Right. Please hold the probe underneath. And now the scissors above it, please, a straight line would be best, yes, and support it from beneath, hold the probe exactly under the scissors. Cut! Good. And now for the first time a clear view! Everything full of clotted blood. This has to go! Now we're removing the clot. Gently wipe it away, don't rub the pericardium, it doesn't like that. Now we have a clear sighting, it won't be long now, we must be at the wound. Don't dilly-dally! It is probably straight ahead of us though it doesn't have to be. Where's the bleeding point? Where's it bleeding from? Look at this sweat! Swab that. Head away, I need to have a look, get out of my way! Swab, don't put your hand in, swab just with the forceps, more gently, energetically, gently I said, gently and energetically at the same time and don't rub, don't chafe! Be careful! Again! Soon we'll have daylight!

'How's the pulse? Something to feel? Nothing? Give her some saline then, as much as you can get in. Blood would be better, blood transfusion, would take too long, we need to know her blood group first, takes too long, saline into the cubital vein, as much as will go — life ersatz, trick blood! And can one of you gentlemen get the laboratory to work out her blood group fast, do we have any blood donors? You once gave us blood, Herr B. Which blood group are you?

'Watch out, only another hundred seconds! Quiet! Let go! Fixation of the heart! With the heart flouncing about like this we'll never do a decent job. It has to be held. It needs to come out of its hiding hole! Out, you coward! I say. We really have to get a hold of it and make it accessible if we want to suture it. Sutures for fixation! Yes, that's the right thread. Thin silk, curved needle, this size must be right, give here, what's all this shilly-shally, don't thread it too short and give me the needleholder at the same time: you hold the pericardium up, and take the end of the thread so that it doesn't trail. Now watch: I'm going to insert it in the serosa of the heart, left ventricle, apex, in, and out again here; now we have a loop; colleague here will hold it for us, and the same again somewhat higher up and somewhat to the right and another loop on the side; now watch, I bring the needle up the heart muscle, needle in, follow through, needle out, remove the needle and tie the ends, and we've done it. Cut the threads and carefully now bring the heart out of the cavity. Is it bleeding? Let it bleed. Of course it's bleeding. Lift it up! Faster, more gently, higher! A little higher perhaps. Nothing to report this side. Nothing on this wall of the heart. Nothing there either. So the other way round! Lift a little please, and around the right side! Firmly and swab again, very finely, without pressing.

'Stop! Stop! Here it is! Here's the wound! Finger in the wound, you, finger on the wound, I said. Bring the wound margins very gently together, give with your hand when the heart beats! That's good. But we want to see something too! Don't press. That's enough. That's good, fine. Ahead now to the heart suture! The same silk as before. First suture, obliquely inserted. Left wound margin, right wound margin, thread out, knot gathered, thread clamped and held. Correct. Take the upper layers. Registrar, take over the suturing and hold the heart wall up to me, no, turn it somewhat to the right, and continue to give with each pulsation of the heart. Good. Second suture. Go somewhat deeper to be on the safe side. In, out, gather the knot, pull together slowly and equally from both sides, and knot again. Less bleeding now, but we're still not quite there! Any pulse to feel? Still nothing? And how is the breathing? Awful? Calmly now. Hand away. Third suture. Good. Bleeding stopped. The heart wound is closed. Scissors, cut the threads of the three sutures! Not too short! But no tail either! No. Good. A fourth? No, that'll do. Leave it. The suture is solid enough, it'll hold when the blood pressure returns and the vessels fill normally.

'Pulse? None? Come then! If the heart's still beating, the man's still living. Look, the heart muscle is recovering visibly, the beats are more prominent, we can see proper systole and diastole now, not the hysterical twitching and fluttering we had earlier. This was a patient in extremis, no doubt about it. So, give a good dose of saline into the cubital, but don't disturb us up here and don't come too close to us with that dirty stuff. Let the mediastinum slip back in, draw the threads out, everything in the right order. Do you see already how the heart muscle is jerking on the three reins like an untrained colt, it is growing stronger under our hands. Good, and the pulse? Hardly palpable. But we can correct that! Give the adrenalin now, we can simply inject the adrenalin solution directly into heart. Good. That was that. And now?'

'The pulse is there, I think.'

'We think so too. And the breathing?'

The student watched the silvery beads of inspired air climb more and more animatedly in the gauge of the anaesthetic device. 'Doing well,' he said.

'Now the pericardial suture. We'll use catgut for that. We couldn't use it for the heart. Silk is safer. But the pericardium doesn't have to withstand the powerful stroke of the heart. That's it, that'll do. Now the ribs back in their old position, we can suture the periosteum with a couple of quick tacks.

A glass drain under the skin. Here, down in the deepest site. Muscle-fascia-wound closure, that is: skin suture, fine silk, only a couple of needle points. Anaesthesia?'

'Off ages ago.'

'Good. Continue the pure oxygen, three-and-a-half litres, four litres, for ever and amen. And camphor to be on the safe side. Head down once she's up in the recovery room too. Blood transfusion only if necessary. Give it if you're in doubt. What blood group is she? A? And you, Herr B.?'

'A, too.'

'We can't have it better than that. Herr Oberarzt and Herr B: remain with the patient. When did we start?'

'Thirteen minutes past eleven.'

'Operating time: seven and a half minutes. A hundred years ago Napoleon's personal physician could take a leg off at the hip in the same time, with stump and pedicle, haemostasis included. They were craftsmen too, but in a different way from us. So, take a hold of the patient very carefully and lift her into the bed; better still, let me do that. There ... there ... Are the bed warmers handy? Cover her! Cover her! Cover her! Splendid. Everything in order. The rest we leave in the hands of fortune. Good morning, gentlemen, good morning.'

Translated from the German by Iain Bamforth, reprinted by kind permission of Liepman Agentur*, Zurich.*

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Iain Bamforth's *The Body in the Library* — a literary anthology of modern medicine (1 85984 534 7) is published by Verso this very month. The blurb is entertaining — 'It provides a nuanced and realistic picture of how medicine and society have abetted and thwarted each other ever since the lawyers behind the French Revolution banished the clergy and replaced them with doctors, the priests of the body. But is that the right way to regard a profession which was once rough trade and arcane learning, which relishes the thespian as much as the white coat, and which, for long enough, saw itself as a branch of criminology?' A review will appear here shortly and in the meantime it sounds like a good Christmas present...
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Roger Neighbour PRCGP promises to play his violin at the Spring Symposium in Bournemouth, another very good reason for going there. We thank him enormously for 20 or so wise and witty *BJGP* columns in the last 2 years.
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Cutting from the *Smallsville Gazette*

YESTERDAY the Smallsville Surgery became the first National Health Service organisation to be awarded Efficiency Beacon status. The award was made at a special ceremony in the House of Commons after a delay caused by the late arrival of Dr Bigge and a few of his practice staff.

Taking the form of a fine, plaque-mounted empty purse, the award was handed over to Dr Bigge by the Secretary of State for Health. Afterwards, in a short speech, the Secretary of State confirmed the significance of the honour, saying: 'It is our hope that many NHS organisations will be able to earn this award in the years to come. It is a measure of the contribution to the modernisation of the [National Health] Service made by the Smallsville Surgery in general and Dr Bigge in particular, that they are the first.'

In a gracious acceptance speech, Dr Bigge, after first apologising for getting lost in what he called 'the unaccustomed vastness' of the House of Commons, warmly thanked the Secretary of State. 'To be the first to receive a new benchmark award is a great honour for me, my patients, and Smallsville' said Dr Bigge. 'The whole village will know that this honour is as much theirs as it is mine.'

The Smallsville Surgery first came to prominence in the 1980s when its cramped upstairs accommodation and substandard care were deemed so poor that the Thriftshire Family Health Services Authority, forerunner of today's Trust Thrift, referred Dr Bigge to the General Medical Council (GMC). Although he was reprimanded on that occasion, he was not prevented from carrying on his practice.

Dr Bigge responded immediately by moving his Surgery downstairs and requiring the students resident there to move upstairs. It was the resultant improvement in access for his patients that spurred Dr Bigge to develop the discipline of patient flow control.
The crux of this new discipline was neatly encapsulated by Dr Bigge in his address to the World Medical Association last year. 'The true aim of medicine', he asserted from the podium, 'is to select from all those who believe themselves to be ill, those who truly are. Those selected few deserve our medicines, the rest exercise.' That the discipline of patient flow control is now firmly a part of mainstream orthodoxy is confirmed by yesterday's events.

Dr Bigge said in a Panorama interview last year that it was trying to admit a patient to hospital that first gave him the idea of patient flow control. The bed bureau operating at the Horatio General Hospital, now part of the Thrift Horatio Hospital Trust, was unable to find a bed for a patient of his, advising that the ambulance should go to casualty. Despite the patient subsequently being in casualty for 3 days, further inquiry by Dr Bigge revealed that the hospital was meeting all targets for time-to-assessment and arrival-to-a-real-proper-cosy-bed and such like.

Transferring into primary care some of the ideas this triggered proved less than straightforward initially and Dr Bigge came close to being referred back to the GMC. Two of his patient flow control ideas have been particularly successful however, and have rescued both his reputation and his practice. One is the introduction of a room manager into his practice, so that himself and his three salaried assistants now work so effectively out of two rooms that Trust Thrift has formally dropped plans to open a new, full size, PFI practice in Smallsville.

The other is the use of the students for assessments on arrival of patients: all patients are now assessed inside 10 minutes. Only those who can convince the students that their failure to complete the stair test is genuine are allowed to go back down and see the doctor.

With his award Dr Bigge also receives an Efficiency Bonus which he intends to spend on a loft conversion, thereby enabling him to conduct experiments on an extended stair test.

New Columnists... call for volunteers!

Alan Munro has completed 6 years before the mast as a *BJGP* columnist, and Jill Thistlethwaite has emigrated to Australia. Very many thanks to both. We'll hear from both again in the future, but less regularly. So two vacancies for regular columnists. We require three columns per year, modestly remunerated.

Sample column of 750 words, plus faint outlines for two more, to **aleclogan@dial.pipex.com** by JANUARY 10, 2004.